Direct Deposit Authorization Form
for Electronic Funds Transfers (EFT) for Medicaid Providers

Payee Information

Name of Business or Individual	Medicaid Provider Number	SSN or EIN

Street Address	City	State	Zip Code

Attach a voided check and sign the *Authorization for Setup* below. (A photocopy of a voided check will not be accepted). Do not attach a deposit slip since deposit slips do not contain sufficient information for processing.

Provide financial institution name, city, state and zip code on this form, and sign the *Authorization for Setup* below.

Financial Institution

Financial Institution Name	City	State	Zip Code

Authorization For Setup

I hereby authorize the State of Utah ("the State") to initiate credit entries to the account number listed above ("this account"). I further authorize the State to correct credit entries made in error to this account. I agree that this AUTHORIZATION FOR SETUP is to remain in full force and effect until the State has received written notification from me of its termination, in such time and manner as to afford the State and the Financial Institution a reasonable opportunity to act upon my notification. I recognize that if I fail to provide complete or accurate information on the above DIRECT DEPOSIT AUTHORIZATION FORM FOR ELECTRONIC FUNDS TRANSFERS (EFT) FOR MEDICAID PROVIDERS ("this form"), the processing of this form may be delayed and/or my payments may be erroneously transferred. In the event that funds are erroneously transferred due to my failure to provide complete or accurate information on this form, I hereby hold the State harmless for the recovery of such erroneous transfers, not withstanding any reasonable attempts made by the State to correct such errors. I understand that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

I, the undersigned certify that I am authorized to provide the above information and the information is true and correct.

Authorized Signature	Date	Telephone Number

Return form to:
Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106

4/14/05